1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11238

CERTIFICATE OF DEATH

11214
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: 8 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ALEXANDER NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR R2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First J — Middle HARRY — Last BARNES

4. DATE OF DEATH: Month OCT — Day 26 — Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN 18-1874
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLUMBER
10b. KIND OF BUSINESS OR INDUSTRY: PLUMBING
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W BARNES
14. MOTHER'S MAIDEN NAME: MARY SIMPSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-10-5410A
INFORMANT: BLAIR SIMPSON
Address: UNION BRIDGE MD RURAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio-Vascular Disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.1
INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/18/60, 19__, to 10/26/60, 19__, that I last saw the deceased alive on 10/24/60, 19__, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. — ADDRESS (Street, city or town, state): New Windsor, Md — DATE SIGNED: 10/26/60

PHYSICIAN'S NAME (Type): M. E. ROBERTSON — NEW WINDSOR MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT 29-1960
22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEM.
22d. LOCATION (City, town, or county): UNIONTOWN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: D N Hartzler & Sons — ADDRESS: Union Bridge Md
24a. REC'D BY REGISTRAR: DATE OCT 31 '60
24b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

11239

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11215

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6yrs.9mos.29days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 340 S. Bouldin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3V01-4

M

015

3. NAME OF DECEASED (Type or print): First: Agnes; Middle: ; Last: Beitz
4. DATE OF DEATH: Month: October; Day: 9; Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? Germany
13. FATHER'S NAME: William Beitz
14. MOTHER'S MAIDEN NAME: Amelia Beitz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Hypertensive and arteriosclerotic cardiovascular disease. — 5 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonitis. -C.B.S.assoc.with senile brain disease with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1960 to Oct. 9, 1960, that (I) (we) last saw the deceased alive on October 9, 1960 and that death occurred at 10:30PM from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/10/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-11-60
23c. NAME OF CEMETERY OR CREMATORY: St.Paul Fifth Reformed
23d. LOCATION (City, town, or county) (State): Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE: William Cook, Inc.,
ADDRESS: 1217 St.Paul Street
25a. REC'D BY REGISTRAR DATE: OCT 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

11240

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11216

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Eldersburg
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: P.O. Sykesville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Eldersburg
d. STREET ADDRESS: P. O. Sykesville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frank Middle S. Last BENNETT
4. DATE OF DEATH: Month Oct Day 4 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 21, 1895
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John R. Bennett
14. MOTHER'S MAIDEN NAME: Elizabeth Shipley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.: 219-01-1678
17. INFORMANT: Mrs. Mary Bennett, Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Carcinoma of lung, Cerebral metastases, — INTERVAL BETWEEN ONSET AND DEATH: 1959
DUE TO
(b) left hemiplegia, Cardiac failure, — 1963
DUE TO
(c) bronchial pneumonia — to 4 Oct 60

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 19__ to 4 Oct 1960, that (I) (we) last saw the deceased alive on 4 Oct 1960 and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4 Oct 60
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.
22d. ADDRESS: Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-7-1960
23c. NAME OF CEMETERY OR CREMATORY: Taylorsville Cemetery
23d. LOCATION (City, town, or county) (State): Carroll Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Md.
25a. REC'D BY REGISTRAR DATE OCT 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11241 11217

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.25days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31 3V01-4
d. STREET ADDRESS: 270 Herring Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara Middle: Gladys Stem Last: Boerner
4. DATE OF DEATH: Month: October Day: 23, Year: 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 18, 1893
9. AGE (In years last birthday): 66 yrs. 66
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harvey W. Stem
14. MOTHER'S MAIDEN NAME: Lilly Engleman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 214-01-1206
17. INFORMANT: Springfield Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(b) Arteriosclerotic cardiovascular disease. — 1 year
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Manic depressive reaction, manic type.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from September 14 1960 to October 23, 1960, that (I) (we) last saw the deceased alive on October 22 1960, and that death occurred at 1:50 AM from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/24/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: Oct 27 1960
23c. NAME OF CEMETERY OR CREMATORY: St Peters Cemetery
23d. LOCATION (City, town, or county) (State): 1300 Moreland Ave Balto Md

24. FUNERAL DIRECTOR'S SIGNATURE: Leo H Cook
ADDRESS: 1701 Patterson Park Ave
25a. REC'D BY REGISTRAR DATE OCT 31 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11234

CERTIFICATE OF DEATH

Reg. Dist. No. 11218

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 39 Webster St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster, Md.
d. STREET ADDRESS 39 Webster St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First ROY Middle ERUIN Last BOHN

4. DATE OF DEATH Month OCT. Day 5 Year 1960

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH Aug. 27 1905

9. AGE (In years last birthday) 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10b. KIND OF BUSINESS OR INDUSTRY Industrial

11. BIRTHPLACE (State or foreign country) Detour Carroll Co. Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ervin Bohn

14. MOTHER'S MAIDEN NAME Ada Bitelee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-09-3662

INFORMANT Mrs. Roy Ervin Bohn, Address Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: about 8 mo
DUE TO
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): (Carcinoma was found during an operation for hiatal hernia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 15, 1960, to Oct. 5th, 1960 that I last saw the deceased alive on Oct. 5th, 1960, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE C. H. Billingslea M.D. — ADDRESS (Street, city or town, state) Westminster, Md. — DATE SIGNED 10-6-60

PHYSICIAN'S NAME (Type) C. H. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10/8/60

22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery

22d. LOCATION (City, town, or county) Rural Westminster (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. — ADDRESS Westminster, Md.

24a. REC'D BY REGISTRAR DATE OCT 10 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

11242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11219

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN Lb.: 2 years. 6 mos. 27 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 12 — 3 Y C 1 - 4
d. STREET ADDRESS: 5 Orkney Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Musser — Last: Bullock
4. DATE OF DEATH: Month: 10 — Day: 14 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 31, 1880
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Musser
14. MOTHER'S MAIDEN NAME: Sarah E. Shiffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with senile brain disease with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 17, 1958, to October 14, 1960, that (I) (we) last saw the deceased alive on October 14, 1960, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: October 14, 1960
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE THEREOF: 10-15-60
23c. NAME OF CEMETERY OR CREMATORY: Union Cemetery
23d. LOCATION (City, town, or county) (State): Belle Fonte, Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. C ok, Inc., 1217 St. Paul Street
25a. REC'D BY REGISTRAR DATE OCT 17 '60
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

11243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11220

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31
d. STREET ADDRESS: 421 Durham St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: C. — Last: Bulter

4. DATE OF DEATH: Month: October — Day: 11 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1880
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: Hair Cutting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick C. Bulterr
14. MOTHER'S MAIDEN NAME: Elizabeth Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the pancreas with billary obstruction — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dementia Praecox, hebephrenic type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/16/10, 19, to 10/11, 1960, that (I) (we) last saw the deceased alive on 10/11, 1960, and that death occurred at 8 P M, from the causes and on the date stated above.

22a. SIGNATURE: Irene R. Hitchman M.D. — M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10/11/60
22c. PHYSICIAN'S NAME (Type): Irene Hitchman, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-14-60
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur H. Haight — ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR — DATE: OCT 17 '60
25b. REGISTRAR'S SIGNATURE: Carlton E. Krause

11244

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11221

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4mos.23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson
d. STREET ADDRESS: White's Ferry
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa Middle: May Last: Cubitt Butler
4. DATE OF DEATH: Month: October Day: 5, Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1882
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Cubitt
14. MOTHER'S MAIDEN NAME: Christine Monred
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

420.0

DUE TO (b) Severe anemia secondary to bleeding esophageal ulcer — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Arteriosclerotic heart disease — Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 12, 1959 to October 5, 1960 that (I) (we) last saw the deceased alive on October 5, 1960, and that death occurred at 11:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/6/60
22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 8-60
23c. NAME OF CEMETERY OR CREMATORY: Monocacy
23d. LOCATION (City, town, or county) (State): Beallsville, Md

24. FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton ADDRESS: Barnesville, Md
25a. REC'D BY REGISTRAR DATE: OCT 11 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

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11245

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11222

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville
c. LENGTH OF STAY IN 1b 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last CAUTHORN
4. DATE OF DEATH Month Oct. Day 22 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Sept. 13 1873
9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Pearson Cauthorn
14. MOTHER'S MAIDEN NAME Elizabeth Wayman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mr Alex Cauthorn Address - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) heart disease, cardiac failure — 1959 to 22 Oct 60

DUE TO (c)

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1957, 19__, to 22 Oct 1960, that (I) (we) last saw the deceased alive on 22 Oct 1960, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE Howard E. Hall M.D.
ATTENDING PHYS. [✓] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED 23 Oct 60
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL
22d. ADDRESS Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 10-24-60
23c. NAME OF CEMETERY OR CREMATORY Harmony
23d. LOCATION (City, town, or county) (State) Cooksville, Howard Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight ADDRESS Sykesville, Md.
25a. REC'D BY REGISTRAR DATE OCT 26 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11236 11223

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN Ib: 51 years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: ~~Baltimore~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: unknown 3 Vol 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA Middle Last DICKEY
4. DATE OF DEATH: Month 10 Day 16 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: about 1879
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: D.E. Schoedler
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Record - Springfield State Hospital Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
(b) Congestive heart failure
DUE TO
(c) Coronary arteriosclerosis

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Days / Month / Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-1 1958 to 10-16 1960, that (I) (we) last saw the deceased alive on 10-16 1960, and that death occurred at 9:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Rita S. Glahn M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-18-60
22c. PHYSICIAN'S NAME (Type): Rita S. Glahn, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 20, 1960
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ellsworth Armacost ELLSWORTH ARMACOST 4600 Liberty Hghts.
25a. REC'D BY REGISTRAR DATE OCT 19 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11247 Item 2 A1-MU272-10-21-60 et 11224

1. PLACE OF DEATH a. COUNTY: Woodbine (Carroll County) MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Golden Age Guest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Md. b. COUNTY: Carroll City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Woodbine Md.~~ Baltimore 3V C1-4
d. STREET ADDRESS: 322 S. Gilmore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRIETT Middle Last ELTON
4. DATE OF DEATH: Month Oct Day 17. Year 1960
5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 3, 1860
9. AGE (In years last birthday): 100 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Bessie Price Address 322 S, Gilmor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b) Cerebral Cutaneous Sclerosis — ?
DUE TO (c) Hypertension — ?

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19 60 to Oct 17 19 60, that (I) (we) last saw the deceased alive on Oct 15 19 60 and that death occurred at 6:15 A.M. from the causes and on the date stated above

22a. SIGNATURE: Morrell N Mastin M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): MORRELL N MASTIN
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10.20.60
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemeetry
23d. LOCATION (City, town, or county) (State): Balto Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Mc. Cully 130 E Fort Ave Balto 30, Md.
25a. REC'D BY REGISTRAR DATE OCT 20 '60
25b. REGISTRAR'S SIGNATURE: Arthur L Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11233 11225

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 60
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 305 Park Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
d. STREET ADDRESS: 305 Park Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie; Middle: Brandenburg; Last: Etchison
4. DATE OF DEATH: Month: October; Day: 16; Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 11, 1878
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Brandenburg
14. MOTHER'S MAIDEN NAME: Elizabeth Mullinix
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Leola Beall. Address: Mt. Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Arteriosclerotic Heart Disease	1 year
DUE TO (b)	Generalized Arteriosclerosis	several years
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October, 1960 to _____, 19____, that (I) (we) last saw the deceased alive on Oct. 14, 1960 and that death occurred at 5 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. B. Culwell — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/16/60
22c. PHYSICIAN'S NAME (Type): W. B. Culwell
22d. ADDRESS: Mount Airy, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 18, 1960
23c. NAME OF CEMETERY OR CREMATORY: Pine Grove
23d. LOCATION (City, town, or county) (State): Mt. Airy, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Mohorith — ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR: DATE OCT 20 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11248 **CERTIFICATE OF DEATH** 11226

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 747 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Croome
d. STREET ADDRESS: 11 -2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First James — Middle Arthur — Last Forbes

4. DATE OF DEATH: Month October — Day 24 — Year 19 60

5 SEX: Male
6. COLOR OR RACE: Negro
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-4-1900
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Croome, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Forbes
14. MOTHER'S MAIDEN NAME: Susie Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-30-3989
17 INFORMANT: James A. Forbes - patient — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular insufficiency
DUE TO
(b) Far advanced pulmonary tuberculosis, left.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

0 0 2X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from June 30, 1958 to Oct. 24, 1960, that (I) (we) last saw the deceased alive on Oct. 24 1960, and that death occurred at 7:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M. D.
ATTENDING PHYS. ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b DATE SIGNED: 10-24-60
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.
22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): 23b DATE THEREOF: 10-24-60
23c NAME OF CEMETERY OR CREMATORY: Woodlawn
23d LOCATION (City, town, or county) (State): West, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Rollins
ADDRESS: 4339 Hunt Pl NE Wash. 19 D.C.
25a. REC'D BY REGISTRAR DATE OCT 26 '60
25b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11249

11227
Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster
c. LENGTH OF STAY IN 1b 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pleasant Valley RD #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster RD #2
d. STREET ADDRESS Pleasant Valley
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First HAZEL Middle FRANCES Last GILBERT

4. DATE OF DEATH Month Oct. Day 14 Year 1960

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct. 20, 1894
9. AGE (In years last birthday) 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Rock Falls Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clifton Campbell
14. MOTHER'S MAIDEN NAME Mary Campbell

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
INFORMANT Mr. Arthur C. Gilbert, Address Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary & Circulatory Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS
153.9
DUE TO (b) adenocarcinoma; intestinal — 10 MONTHS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1960, to October, 1960, that I last saw the deceased alive on October 12, 1960, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE David I. Welliver M.D. ADDRESS (Street, city or town, state) 19 RIDGE ROAD DATE SIGNED 10-14-60

PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER WESTMINSTER MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 17, 60
22c. NAME OF CEMETERY OR CREMATORY Hunters Cemetery
22d. LOCATION (City, town, or county) (State) Rural Westminster Md.

23. FUNERAL DIRECTOR'S SIGNATURE L. E. Fickes, Jr. ADDRESS Westminster Md.
24a. REC'D BY REGISTRAR DATE OCT 19 '60
24b. REGISTRAR'S SIGNATURE Carlton S. Knox

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11228

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millers (Rural)
c. LENGTH OF STAY IN 1b: 30 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millers - Rural
d. STREET ADDRESS: ✓
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES Middle T Last HARE
4. DATE OF DEATH: Month Oct Day 24 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept 6 - 1887
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John T Hare
14. MOTHER'S MAIDEN NAME: Martha Bumbleitz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-36-4962
17. INFORMANT: Mrs James Hare — Address: Hampstead, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b) Coronary Insufficiency — 3 yrs
DUE TO
(c) Coronary Ateriosclerosis — Unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1957, to October 24 1960, that (I) (we) last saw the deceased alive on Oct. 20 1960, and that death occurred at 2:30 A.M., from the causes and on the date stated above

22a. SIGNATURE: M. C. Porterfield M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): M.C. Porterfield
22d. ADDRESS: Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 27/60
23c. NAME OF CEMETERY OR CREMATORY: Grace Run
23d. LOCATION (City, town, or county) (State): Baltimore Md
24. FUNERAL DIRECTOR'S SIGNATURE: Edw. C. Tipton — ADDRESS: Hampstead Md
25a. REC'D BY REGISTRAR DATE OCT 26 '60
25b. REGISTRAR'S SIGNATURE: Clarence S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11251 11229

CERTIFICATE OF DEATH

Item 1 rim 6274 11-7-60 et

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 Mos. 24 Dys.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Balto.~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14
d. STREET ADDRESS: 3305 Glenmore Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances; Middle: Dressel; Last: Haynes
4. DATE OF DEATH: Month: Oct.; Day: [illegible]; Year: 19[illegible]
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 24, 1875
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Female HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): Maryland, BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Dressel
14. MOTHER'S MAIDEN NAME: Margaret
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): –
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerot. heart disease
DUE TO (b) Diabetes mellitus
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

26CX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic depressive reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 8-6, 1960 to 10-30, 1960, that (I) (we) last saw the deceased alive on 10-30 1960, and that death occurred at 6:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-30-60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 11/2/60
23c. NAME OF CEMETERY OR CREMATORY: LORRAINE PARK CEMETERY
23d. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HENRY SANDER & SONS INC BALTO. MD.
25a. REC'D BY REGISTRAR — DATE: NOV 1 '60
25b. REGISTRAR'S SIGNATURE: Cecilia S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 [illegible] after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 8/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11231 11230

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 2 yrs X
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long View Nurs Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester R.D.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle A Last HERSH

4. DATE OF DEATH: Month October Day 4 Year 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-10-1877
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Kreitzer
14. MOTHER'S MAIDEN NAME: Barbara Haber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: No
17. INFORMANT: John Hesh — Manchester Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Colloid Goitre (Thyroid) with Tracheal compression
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1957 to Oct 4 1960 that (I) (we) last saw the deceased alive on Oct 3 1960 and that death occurred at 5:45 A.M. P.M. from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-6-60
22c. PHYSICIAN'S NAME (Type): W H Foard M.D
22d. ADDRESS: Manchester, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 7-1960
23c. NAME OF CEMETERY OR CREMATORY: Manchester
23d. LOCATION (City, town, or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Edw C Napton
ADDRESS: Hampstead Md
25a. REC'D BY REGISTRAR DATE OCT 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11231

11272

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where decedent lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City 30

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 moths.9 days.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital.

d. STREET ADDRESS: 3123 Fleet St Balto.24

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Hoesch

4. DATE OF DEATH: Month 10 – Day 8 – Year 19 60

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-21-75

9 AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hoesch

14. MOTHER'S MAIDEN NAME: Margaret Schmidt

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis — years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-29 – 1960 to 10-8- 1960, that (I) (we) last saw the deceased alive on 10 – 8 – 1960, and that death occurred at 10.30 P.M. from the causes and on the date stated above

22a SIGNATURE: Agustin del Campo. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 10-9-60

22c PHYSICIAN'S NAME (Type): Agustin del Campo.M.D.

22d. ADDRESS: Sykesville,Maryland.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10-12-1960

23c NAME OF CEMETERY OR CREMATORY: Holy Redeemer

23d LOCATION (City, town, or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Lilly & Zeiler Inc. — ADDRESS: 1901 Eastern Avenue

25a REC'D BY REGISTRAR — DATE: OCT 11 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11253 **CERTIFICATE OF DEATH** Reg. Dist. No. 11232

1 PLACE OF DEATH
a. COUNTY Carroll MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg
c. LENGTH OF STAY IN 1b 25 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarhurst Road
d. STREET ADDRESS Cedarhurst Road
e IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First Thomas Middle Stephen Last Jones
4. DATE OF DEATH Month October Day 18 Year 19 60

5. SEX Male
6. COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-12-1871
9 AGE (In years last birthday) 85 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas S. Jones
14. MOTHER'S MAIDEN NAME Angeline Seller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.
INFORMANT Herman S. Jones Address Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
422.1
DUE TO (b) Arteriosclerotic Cardio-Vascular Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Squamous cell carcinoma lower lip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7-20- 1954 to 10-18 1960 that I last saw the deceased alive on 10-13 - 1960, and that death occurred at 8:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Martin E. Strobel M.D. ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 10-18-60

PHYSICIAN'S NAME (Type) Martin E. Strobel M.D. Reisterstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-21-60
22c NAME OF CEMETERY OR CREMATORY Deer Park Cemetery
22d. LOCATION (City, town, or county) (State) Smallwood, Carroll Md.

23 FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE OCT 21 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11254 **CERTIFICATE OF DEATH** 11233

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 4days,12 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore Co.03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4
d. STREET ADDRESS 1707 Aberdeen Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Sadie Middle Last Kanzler
4. DATE OF DEATH Month Oct. Day 9 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 6-9-72
9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert McElwee
14. MOTHER'S MAIDEN NAME Jennie Jordon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH years
DUE TO (b) Generalized arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome due to arteriosclerosis cerebral and generalized.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-4 - 1960, to 10-9- 1960, that (I) (we) last saw the deceased alive on 10-9- 1960, and that death occurred at 3.35 A.M. from the causes and on the date stated above

22a. SIGNATURE Agustin del Campo M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED 10-8-60
22c. PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.
22d. ADDRESS Sykesville, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE THEREOF 10-12-60
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery
23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck 5305 Harford Rd.
25a. REC'D BY REGISTRAR DATE OCT 13 '60
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11255 **CERTIFICATE OF DEATH** 11234

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Md.
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sykesville

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cooksville
d. STREET ADDRESS: Cooksville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard Middle P. H. Last Kelley
4. DATE OF DEATH: Month October Day 3, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1908
9. AGE (In years last birthday): 52 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk Springfield State Hospital
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James B. Kelley
14. MOTHER'S MAIDEN NAME: Bertha Phillips
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 155-12-6150
17. INFORMANT: Mrs. H. H. Kelley (Wife) Address: Cooksville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EMBOLISM of CORONARY ARTERY — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10.3.60 19___ to 10.3.60 19___ that (I) (we) last saw the deceased alive on 10.3.60 19___ and that death occurred at 10.40AM from the causes and on the date stated above.

22a. SIGNATURE: Wm. H. Lawson, Jr. M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10.3.60
22c. PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.
22d. ADDRESS: Sykesville-2, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-5-1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Robert E. Wiley Jr.
ADDRESS: Frederick, Maryland
25a. REC'D BY REGISTRAR: DATE OCT 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11235

CERTIFICATE OF DEATH

11256

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster #2
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: R.D. #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Arnold Middle: Last: Krumrine
4. DATE OF DEATH: Month: October Day: 26 Year: 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/18/1874
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 1945 Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Krumrine
14. MOTHER'S MAIDEN NAME: Rebecca Shaeffer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Wm. Albert Reifsnider — Address: Westminster Md #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.
331 X
DUE TO (b) Senility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) High Blood Pressure — Diabetes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 19 60 to 10/26/60, 19 60, that I last saw the deceased alive on 10/26 19 60, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George P. Ord M.D. ADDRESS (Street, city or town, state): Hanover Pa DATE SIGNED: 10/27/60
PHYSICIAN'S NAME (Type): George P. Ord Hanover Pa

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/60
22c. NAME OF CEMETERY OR CREMATORY: St. Bartholomews
22d. LOCATION (City, town, or county) (State): Hanover Pa York Co.
23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Becker ADDRESS: Hanover Pa
24a. REC'D BY REGISTRAR DATE: OCT 31 '60
24b. REGISTRAR'S SIGNATURE: Arthur J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11257 11236

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9yrs.1mo.6days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14
d. STREET ADDRESS: 5506 Morello Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Elizabeth Last: Kummer
4. DATE OF DEATH: Month: October Day: 25, Year: 19 60
5. SEX: Female 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1919
9. AGE (In years lost birthday): 41 yrs IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesgirl
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles A. Kummer
14. MOTHER'S MAIDEN NAME: Nettie Bickel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, hebephrenic type.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Sept. 14, 1960 to October 25, 1960, that (I) (we) last saw the deceased alive on October 25, 1960 and that death occurred at 10:30 AM from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED: 10/25/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/29/60
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem Cem
23d. LOCATION (City, town, or county) (State): Finksburg Md
24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Leonard J. Rick 5305 Harford Rd
25a. REC'D BY REGISTRAR DATE OCT 27 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11258 11257

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Taneytown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Evelyn Middle Elizabeth Last Lawrence

4. DATE OF DEATH: Month October Day 10 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1912
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herbert Eyler
14. MOTHER'S MAIDEN NAME: Lottie Heffner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mr. Wilbur Lawrence, Taneytown, Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b) Carcinomatosis — 3 years
DUE TO (c) Papillary Adenocarcinoma of Ovaries — 3½ yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/6 1960 to 10/10 1960, that (I) (we) last saw the deceased alive on 10/9 1960 and that death occurred at 8:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. S. McVaugh M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10/10/60
22c. PHYSICIAN'S NAME (Type): R. S. McVaugh
22d. ADDRESS: Taneytown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/12/60
23c. NAME OF CEMETERY OR CREMATORY: Baust Cemetery
23d. LOCATION (City, town, or county) (State): Tyrone, Carroll, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Mervyn C. Fuss
ADDRESS: C. O. Fuss & Son Taneytown, Maryland
25a. REC'D BY REGISTRAR DATE OCT 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/58

Data Inc. Fin.
11-4-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11259 Reg. Dist. No. 11238

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upperco - Rural
d. STREET ADDRESS: RFD-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLAUDE Middle E Last LEIGHT
4. DATE OF DEATH: Month Oct Day 30 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-9-1889
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: Bank
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Leight
14. MOTHER'S MAIDEN NAME: Adelie Trouble
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-7177
17. INFORMANT: Mrs Homer Snyder Address: Hampstead Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured Skull
812X
DUE TO (b): Auto Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - struck by automobile
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hampstead
20f. (City or town) Hampstead (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/30/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 2/60
22c. NAME OF CEMETERY OR CREMATORY: Emory Meth.
22d. LOCATION (City, town, or county) (State): Carroll Co Md
23. FUNERAL DIRECTOR'S SIGNATURE: Edel C Upton ADDRESS: Hampstead Md
24a. REC'D BY REGISTRAR DATE NOV 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11260 11239

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: D.C. b. COUNTY: Montomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 809 Violet Place,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Adam Last Lindner
4. DATE OF DEATH: Month October Day 12 Year 19 60

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/26/69
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months 2 Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lindner
14. MOTHER'S MAIDEN NAME: Emily Huldie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Springfield State Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: days

420.0

DUE TO (b) Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Arteriosclerotic Heart Disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile psychosis, paranoid with hypertension and generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/16, 1960 to 10/12, 1960, that (I) (we) last saw the deceased alive on 10/12 1960, and that death occurred at 7:15 AM, from the causes and on the date stated above

22a. SIGNATURE: Ellis S. Margolin M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 11/12/60
22c. PHYSICIAN'S NAME (Type): Ellis S. Margolin, M.D.
22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 4. 1960
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Lenton Rectors ADDRESS: 257 Carroll St NW DC
25a. REC'D BY REGISTRAR DATE OCT 13 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs. after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4) 15M 11/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11232 **CERTIFICATE OF DEATH** 11240

Items 1, 14 filed 273 10-19-60 et

1. PLACE OF DEATH a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 19 Locust Street (private home)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Greenmount, Maryland
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: HENRY Last: Mahaley.
4. DATE OF DEATH: Month: October Day: 11 Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 10, 1879
9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer.
10b. KIND OF BUSINESS OR INDUSTRY: Canning Factory
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Mahaley.
14. MOTHER'S MAIDEN NAME: Christina Kaugle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-09-0695
17. INFORMANT: Mrs Chas Mahaley Address: Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1yr
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
151 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arterio-Sclerotic Cardio Vascular Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 15 1960 to Oct 11 1960, that (I) (we) last saw the deceased alive on Oct 11 1960, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Bush M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-11-60
22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD
22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-14-60
23c. NAME OF CEMETERY OR CREMATORY: Manchester
23d. LOCATION (City, town, or county) (State): Bellvail Md

24. FUNERAL DIRECTOR'S SIGNATURE: Giles A. Tipton ADDRESS: Hampstead Md
25a. REC'D BY REGISTRAR DATE: OCT 14 '60
25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11261 11241

1 PLACE OF DEATH a. COUNTY: Carroll (MARYLAND)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3yrs.2mos.17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 307 Herring Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John; Middle; Last Masijauskas
4. DATE OF DEATH: Month October; Day 7; Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 1, 1868
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY? Naturalized
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 217-14-2405
17. INFORMANT: Springfield Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Arteriosclerotic cardiovascular disease — 1 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with circ.dist.,with cerebral arteriosclerosis, with psychotic reaction. Renal nephrosclerosis.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/14/60, 19__, to October 7, 1960, that (I) (we) last saw the deceased alive on 10/7/60, 19__, and that death occurred at 1:35 PM from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/7/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: Oct. 10, 1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
23d. LOCATION (City, town, or county) (State): O'Donnell St. Balto. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: JOHN J. DUDA ADDRESS: 7922 Wise Avenue 22, Md.
25a. REC'D BY REGISTRAR DATE OCT 11 '60
25b. REGISTRAR'S SIGNATURE: Charles S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11262 11242

1 PLACE OF DEATH a. COUNTY: CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
c. LENGTH OF STAY IN 1b: 5 MOS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PULLEN NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FULLERTON
d. STREET ADDRESS: EAST JOPPA ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ROSETTA Middle Last McDANIEL
4. DATE OF DEATH: Month 10 Day 9 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF [redacted]H: 9/4/1886
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: CHARLES LESTER
14. MOTHER'S MAIDEN NAME: RENO SIMMONS
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 229-14-4002
17. INFORMANT: POSEY L. McDANIEL Address: 2324 E JOPPA RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Arteriosclerotic heart Dis. — INTERVAL BETWEEN ONSET AND DEATH: June 60 to
DUE TO (b) Acute arteriosclerosis Gangrene of — June 60 to
DUE TO (c) both feet & legs. — 9 Oct 60

H-53.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June 1960 to 9 Oct 1960, that (I) (we) last saw the deceased alive on 9 Oct 1960 and that death occurred at 7:30 PM, from the causes and on the date stated above

22a SIGNATURE: Howard E Hall M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT. 20, 1960
23c NAME OF CEMETERY OR CREMATORY: WHITE OAK GROVE
23d LOCATION (City, town, or county) (State): ROANOKE VIRGINIA
24. FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home ADDRESS: 7401 Belair Rd #6.
25a. REC'D BY REGISTRAR DATE: OCT 14 '60
25b REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

11263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11243

1 PLACE OF DEATH a. COUNTY: Carroll — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Woodbine

c. LENGTH OF STAY IN 1b: Life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R. F. D. 1

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Carroll

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Woodbine

d. STREET ADDRESS: R. F. D. 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle M. Last MILLER

4. DATE OF DEATH: Month October Day 3, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: July 29, 1912

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: State Hosp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: J. Donald Miller

14. MOTHER'S MAIDEN NAME: Mary C. Bloom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ---------- (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO: 220-18-1360

17. INFORMANT: Mrs. Mary C. Miller, Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM OF CORONARY ARTERY — INTERVAL BETWEEN ONSET AND DEATH: 30 min-

420-1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1935, 19__, to 10/3, 1960, that (I) (~~we~~) last saw the deceased alive on 10/3 1960, and that death occurred at 5:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. H. Lawson Jr. M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 10/3/60

22c. PHYSICIAN'S NAME (Type): Wm H. LAWSON, JR, M.D.

22d. ADDRESS: SYKESVILLE, MD.

23a. BUR A., CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct.6,1960

23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery

23d. LOCATION (City, town, or county) (State): Sykesville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 7 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

11264

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11244

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 30yrs.1mo.17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1633 S. Charles St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: ; Last: Moran
4. DATE OF DEATH: Month: October; Day: 19; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 5, 1905
9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Timothy J. Moran
14. MOTHER'S MAIDEN NAME: Katherine Imhoff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: -
17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of lungs — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
162X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, hebephrenic type.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/27/55, 19__, to October 19, 1960, that (I) (we) last saw the deceased alive on October 18 1960, and that death occurred at 7:55 AM from the causes and on the date stated above.

22a. SIGNATURE: Julian Radzykowycz M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/19/60
22c. PHYSICIAN'S NAME (Type): Julian Radcykowycz, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/22/60
23c. NAME OF CEMETERY OR CREMATORY: Holy Cross
23d. LOCATION (City, town, or county) (State): Reisterstown Highway
24. FUNERAL DIRECTOR'S SIGNATURE: John J. Fahrenholz
ADDRESS: 1318 Light
25a. REC'D BY REGISTRAR: OCT 21 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Freeman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11265 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 11245

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: MARYLAND 9 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sykesville

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
d. STREET ADDRESS: Sykesville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Summers Last PICKETT
4. DATE OF DEATH: Month Oct. Day 30, Year 1960 19
5. SEX: mal
6. COLOR OR RACE: wh
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 15, 1903
9. AGE (In years birthday) 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryalnd
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Edward Summer Pickett
14. MOTHER'S MAIDEN NAME: Olevia Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-01-9844
17. INFORMANT: Mrs. Elizabeth M. Pickett, Address: Same as 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Near-contact gunshot wound of head
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) Found shot in head
20c. TIME OF INJURY Hour a.m. p.m. 6:45 am Month, Day, Year 10/30/60 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Sykesville (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: W. Bradley King M.D.
EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
DATE SIGNED 10/30/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel Cemetery
22d. LOCATION (City, town, or country): Carroll Co. (State) Maryland

23. FUNERAL DIRECTOR: C. M. Waltz, ADDRESS: Winfield, Maryland
24a. REC'D BY REGISTRAR DATE NOV 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

11266

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11246

Item 1 Filed 2/3 10-27-60 et

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 26 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6912 Woodside Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen; Middle: Hussell; Last: Potts
4. DATE OF DEATH: Month: 10; Day: 15; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 5, 1888
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architecture
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Peter Wilson Potts
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Kellough
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b) Pulmonary embolism
DUE TO
(c) Thrombophlebitis left leg. — days

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/19/60 19__ to 10/15/60 19__, that (I) (we) last saw the deceased alive on 10/15/60 19__, and that death occurred at 8:45 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/15/60
22c. PHYSICIAN'S NAME (Type): Augustin del Campo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 10/17/60
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE OCT 18 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

11267

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11247

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 4,453 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparrows Point
d. STREET ADDRESS: 724 I Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: — Last: Preston
4. DATE OF DEATH: Month: October — Day: 18 — Year: 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 27, 1913
9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plate Grinder
10b. KIND OF BUSINESS OR INDUSTRY: Shipyard
11. BIRTHPLACE (State or foreign country): Appomattox, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stephen Preston
14. MOTHER'S MAIDEN NAME: Josephine Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 718-12-9444
17. INFORMANT: Douglas Preston - Patient — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
002X
DUE TO
(b) Far adv. bilateral cavitary pulmonary tbc. — 12 years
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 9, 1948 to Oct. 18, 1960 that (I) (we) last saw the deceased alive on Oct. 18 1960, and that death occurred at 2:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10-18-60
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.
22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/22/60
23c. NAME OF CEMETERY OR CREMATORY: Galilee Baptist Cem.
23d. LOCATION (City, town, or county) (State): Appomattox Co. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: West Funeral Home Appomattox Va.
25a. REC'D BY REGISTRAR DATE: OCT 24 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11268 — Reg. Dist. No. 11248

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mullers, Rural
c. LENGTH OF STAY IN 1b: 2-4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mullers - Rural
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle IRVING Last PAUSBACK
4. DATE OF DEATH: Month Oct Day 26 Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 4 - 1891
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: General Labor
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Jeremiah Pausback
14. MOTHER'S MAIDEN NAME: Mary E Baxter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 710
17. INFORMANT: Mrs. Irvin Pausback Address: Hampstead Md. R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion

4 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James T. Marsh M.D.
EXAMINER'S NAME (Type): JAMES T MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/26/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-29-60
22c. NAME OF CEMETERY OR CREMATORY: Fairview Park
22d. LOCATION (City, town, or county) (State): Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE: Edward D. Upton ADDRESS: Hampstead Md
24a. REC'D BY REGISTRAR DATE OCT 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kness

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11260 Item 23a,b,c,& d, [illegible] 11/1/60 iwk 11249

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
d. STREET ADDRESS: 306 W. Chapline St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Della — Middle: May — Last: Drenner Renner
4. DATE OF DEATH: Month: October — Day: 30, — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 25, 1884
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas Drenner
14. MOTHER'S MAIDEN NAME: Mary Jane Domer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: -
17. INFORMANT: Springfield Hospital Records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute suppurative nephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
DUE TO
(b) Bilateral bronchopneumonia. — 1 week.
DUE TO
(c)

490x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with senile brain disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1960, to 10/30/60, 19 ... that (I) (we) last saw the deceased alive on 10/30/60 19 ..., and that death occurred at 2:25 PM from the causes and on the date stated above

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/31/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/2/1960
23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery
23d. LOCATION (City, town, or county) (State): Sharpsburg, Maryland.

24a. FUNERAL DIRECTOR'S SIGNATURE: Clifford Stetson
ADDRESS: Williamsport, Md.
Leaf Funeral Home, Williamsport, Md.

25a. REC'D BY REGISTRAR DATE NOV 2 '60
25b. REGISTRAR'S SIGNATURE: Clifford E. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11270

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11250

1. PLACE OF DEATH — COUNTY: Carroll — MARYLAND

1b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville

c. LENGTH OF STAY IN 1b: 1y. 3m. 15d.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery ✓

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Maryland 1517-2

d. STREET ADDRESS: 9 Pine Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fannie Middle: Hobdy Last: Richmond

4. DATE OF DEATH: Month: 10 Day: 3 Year: 1960

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/14/1869

9. AGE (In years last birthday): 91 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Swan

14. MOTHER'S MAIDEN NAME: Minerva Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO (b) Arteriosclerotic heart disease — years

DUE TO (c) Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

429.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome associated with senile brain disease with psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 6/18 1959 to 10/3 1960, that ☒ (we) last saw the deceased alive on 10/3 1960, and that death occurred at 8:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: Rita S. Glahn M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 10/4/60

22c. PHYSICIAN'S NAME (Type): Rita S. Glahn, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 6, 1960

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery

23d. LOCATION (City, town, or county) (State): Prince George County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walton

ADDRESS: 254 Carroll St. NW. D.C.

25a. REC'D BY REGISTRAR: OCT 6 60 DATE

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11271 **CERTIFICATE OF DEATH** 11251

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5mos.11days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21 CSX
d. STREET ADDRESS: 7206 Golden Ring Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George Middle: Last: Riess
4. DATE OF DEATH: Month: October Day: 13, Year: 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 12, 1887
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? Naturalized

13. FATHER'S NAME: Jacob Riess
14. MOTHER'S MAIDEN NAME: Anna - Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 212-30-3247
17. INFORMANT: Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

490X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pre-senile psychosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 19 60 to Oct. 13, 1960, that (I) (we) last saw the deceased alive on Oct. 13, 19 60 and that death occurred at 11PM, from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/14/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-17-1960
23c. NAME OF CEMETERY OR CREMATORY: London-Park Cem.
23d. LOCATION (City, town, or county) (State): Baltimore Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Lassahn Funeral Home ADDRESS: 7401 Belair Road
25a. REC'D BY REGISTRAR DATE OCT 17 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11272 **CERTIFICATE OF DEATH** 11252

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenmount
c. LENGTH OF STAY IN 1b: 5-yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ✓

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenmount
d. STREET ADDRESS: ✓
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First JOHN — Middle FRANK — Last RINEHART
4. DATE OF DEATH: Month Oct — Day 29 — Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept 6 - 1869
9. AGE (In years last birthday): 91 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Laborer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Henry Rinehart
14. MOTHER'S MAIDEN NAME: Mandilla Herbert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — If yes, give war or dates of service:
16. SOCIAL SECURITY NO.: 212-24-7217
17. INFORMANT: Mrs F.C. Gapenski — Address: 4347 Sheldon, Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Benign Prostatic Hypertrophy
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1960, 19__, October 29, 1960, that (I) (we) last saw the deceased alive on 10-29, 1960, and that death occurred at 4 p.m. from the causes and on the date stated above

22a. SIGNATURE: M.C. Porterfield M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): M.C. Porterfield
22d. ADDRESS: Hampstead, md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 11-1-1960
23c. NAME OF CEMETERY OR CREMATORY: Manchester
23d. LOCATION (City, town, or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Edw C Tipton — ADDRESS: Hampstead Md
25a. REC'D BY REGISTRAR: DATE NOV 1 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11273

CERTIFICATE OF DEATH

11253

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
f. STREET ADDRESS: 19 Newcut Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: Alexander — Last: Rogers
4. DATE OF DEATH: Month: October — Day: 1, — Year: 1960
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-?-1908
9. AGE (In years last birthday): 52 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Landscaper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Granite, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Will Rogers
14. MOTHER'S MAIDEN NAME: Ollie Hall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 220-24-3764
17. INFORMANT: George A. Rogers - Patient — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular insufficiency
759.0
DUE TO (b) Cystic disease of both lungs and pneumonitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1960 to Oct. 1, 1960 that (I) (we) last saw the deceased alive on Oct. 1, 1960 and that death occurred at 9 15 P M, from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. M.D
ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.
22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct 3 1960
23c. ~~NAME OF CEMETERY OR CREMATORY~~: Druid Ridge Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Hiseell — ADDRESS: Pikesville Md.
25a. REC'D BY REGISTRAR — DATE: OCT 13 '60
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11235 Reg. Dist. No. 11254

1. PLACE OF DEATH a. COUNTY: CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 4 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 131 JOHN STREET.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEWIS Middle HOWELL Last SCHNAUBLE
4. DATE OF DEATH: Month OCTOBER Day 23 Year 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 18 1887
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME: CHRISTIAN F. M. SCHNAUBLE
14. MOTHER'S MAIDEN NAME: LAURA CLEFFLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-12-5093
17. INFORMANT: MRS. GRACE SCHNAUBLE (WIFE) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 18 MONTHS
422.1
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 20 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY, 1959, to OCTOBER, 1960, that I last saw the deceased alive on OCTOBER 23, 1960, and that death occurred at 9:43 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel I. Welliver M.D. ADDRESS (Street, city or town, state): 19 RIDGE ROAD DATE SIGNED: OCT 23 1960
PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER WESTMINSTER MARYLAND.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/26/60
22c. NAME OF CEMETERY OR CREMATORY: MT. PLEASANT
22d. LOCATION (City, town, or county) (State): GAMBER. MD.
23. FUNERAL DIRECTOR'S SIGNATURE: James G. Saffell ADDRESS: Westminster Md.
24a. REC'D BY REGISTRAR DATE: OCT 25 '60
24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11236 **CERTIFICATE OF DEATH** 11255

Item 9 filmG2/3, 10-20-60 el

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 9yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 74 W. Green St.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 74 W. Green St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PAUL Middle Last SHIPLEY
4. DATE OF DEATH: Month Oct Day 19 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 20 1889
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Westminster Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Rev. David F. Shipley
14. MOTHER'S MAIDEN NAME: Genevieve Lambert
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mrs. Paul Shipley, Address: Same address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

192X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paralysis Agitans
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Oct 10 1949 to Oct 19 1960, that (I) (we) last saw the deceased alive on Oct 19 1960, and that death occurred at 7:45 P.M. from the causes and on the date stated above

22a. SIGNATURE: Julius Chepko M.D.
ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/20/60
22c. PHYSICIAN'S NAME (Type): Julius Chepko
22d. ADDRESS: 85½ W. Green St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/24/60
23c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
23d. LOCATION (City, town, or county) (State): Westminster Md
24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr.
ADDRESS: Westminster Md
25a. REC'D BY REGISTRAR DATE: OCT 21 '60
25b. REGISTRAR'S SIGNATURE: Clinton S. Fraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

11274

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11256

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5 years 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: City311
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 31
d. STREET ADDRESS: 2235 Lamley St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Homer Middle: Last: Slemp
4. DATE OF DEATH: Month: October Day: 16 Year: 1960
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: May 10, 1888
9. AGE (In years lost birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patton Slemp
14. MOTHER'S MAIDEN NAME: Martha Slemp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 1911-14
16. SOCIAL SECURITY NO.: 401 01 1483
17. INFORMANT: Springfield State Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: minutes
420.0
DUE TO (b) Arteriosclerotic Heart Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS-assoc. with circulatory disturbance-cerebral arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-15- 1955 to 10-16 1960, that (I) (we) last saw the deceased alive on 10-16 1960, and that death occurred at 1 A.M. from the causes and on the date stated above
22a. SIGNATURE: Julian Radzykewycz M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Julian Radzykewycz, MD
22d. ADDRESS: Springfield Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-19-60
23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore, Maryland.
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Cook Blight Inc. 6009 Harford Rd. (14)
25a. REC'D BY REGISTRAR DATE: OCT 19 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

11273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11257

M

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.7mos.13days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 12
d. STREET ADDRESS: 1236 E. Belvedere Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Alexander — Last: Smoot
4. DATE OF DEATH: Month: October — Day: 16, — Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 15, ~~1902~~ 1895
9. AGE (In years last birthday): ~~58~~ 65
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacturer of storm
10b. KIND OF BUSINESS OR INDUSTRY: windows -
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Gerard Smoot (Gerard Wood Crain Smoot)
14. MOTHER'S MAIDEN NAME: Verlinda Brawner
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1917 - 1942
16. SOCIAL SECURITY NO: 188-01-1320
17 INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the larynx — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
161 X
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S.assoc.with cerebral arteriosclerosis without qualifying phrase.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March 3, 19 59, to October 16, 19 60 that (I) (we) last saw the deceased alive on October 16, 19 60, and that death occurred at 6:30 PM from the causes and on the date stated above

22a SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/17/60
22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 10/19/60
23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cem.
23d. LOCATION (City, town, or county) (State): Baltimore, Md.
24 FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible] Md
25a REC'D BY REGISTRAR: DATE OCT 18 '60
25b REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11276

Reg. Dist. No. 11258

1 PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MIDDLEBURG
c. LENGTH OF STAY IN 1b: MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BROOKFIELD MANOR N. H.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: 1 RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARY Middle ELLEN Last STALLINGS
4. DATE OF DEATH: Month OCT Day 7 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 16 MAR. 1875
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: GERARD KREIMER
14. MOTHER'S MAIDEN NAME: ELIZABETH EKING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-36-8696
INFORMANT: MRS GRAFTON BOONE — Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic Cardio-Vascular
DUE TO
(b): disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES [ ] NO [ ]
20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 3/7/58, 19__, to 10/7/60, 19__, that I last saw the deceased alive on 10/7/60, 19__, and that death occurred at 11 30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D — ADDRESS (Street, city or town, state): New Windsor, Md — DATE SIGNED: 10/8/60
PHYSICIAN'S NAME (Type): M.E. ROBERTSON — NEW WINDSOR MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11 OCT 1960
22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN CEM
22d. LOCATION (City, town, or county) (State): UNIONTOWN MD
23. FUNERAL DIRECTOR'S SIGNATURE: C.W. Hartsfield Sons — ADDRESS: UNION BRIDGE MD.
24a. REC'D BY REGISTRAR: DATE OCT 13 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 [illegible] after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1

11277

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11259

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.10mos.18days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 1
d. STREET ADDRESS: 837 Hamilton Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

015

3. NAME OF DECEASED (Type or print): First Alice — Middle Stanley — Last Tucker
4. DATE OF DEATH: Month October — Day 1, — Year 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 24, 1882
9. AGE (in years last birthday): 78 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: William Tucker
14. MOTHER'S MAIDEN NAME: Blanche~~Ada~~ O'Hara
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 216-07-8024A
17. INFORMANT: Springfield Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 11 days
491 X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
C.B.S.assoc.with alcohol intoxication with psychotic reaction.
Arteriosclerotic cardiovascular disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/14/60, 19__, to 10/1/60, 19__, that (I) (we) last saw the deceased alive on 10/1/60, 19__, and that death occurred at 2:45PM from the causes and on the date stated above.

22a. SIGNATURE: J. Raymond Gladue M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 10/2/60
22c. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10/4/60
23c. NAME OF CEMETERY OR CREMATORY: All Hallows Cem.
23d. LOCATION (City, town, or county) (State): Birdsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Tickner & Sons
ADDRESS: 1 W. Pratt St.
25a. REC'D BY REGISTRAR: DATE OCT 4 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Simms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11278

CERTIFICATE OF DEATH

12054

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 605 Pierce Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine Middle: Reaves Last: Walker
4. DATE OF DEATH: Month: 10 Day: 29 Year: 1960
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 3, 1931
9. AGE (In years lost birthday): 29 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wilmington, N.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James Ryams
14. MOTHER'S MAIDEN NAME: Clara Reaves
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Catherine Walker Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Insufficiency

DUE TO (b) Fibrosis of lungs, far advanced bilateral pulmonary tuberculosis

DUE TO (c) Chronic alcoholism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 30 1960 to Oct. 29 1960 that (I) (we) last saw the deceased alive on Oct. 29 1960, and that death occurred at 5:45P M. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☒ STAFF PHYS ☐
22b. DATE SIGNED: 10-29-60
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M.D.
22d. ADDRESS: Henryton State Hospital, Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Nov. 4-60
23c. ~~NAME OF CEMETERY OR CREMATORY~~: Pleasant Grove
23d. LOCATION (City, town, or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank H. Merrill ADDRESS:
25a. REC'D BY REGISTRAR DATE NOV 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

11279 **CERTIFICATE OF DEATH** 11260

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1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 1 yr. 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3 V 01 -4
d. STREET ADDRESS: 2215 Chaptank Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie (Anna) Middle: Last: Williams
4. DATE OF DEATH: Month: 10 Day: 10 Year: 19 60
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/15/72
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packing house
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Weidinger
14. MOTHER'S MAIDEN NAME: Cunegunde (unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Springfield Hosp. records Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic heart failure — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
(b) Rheumatic heart disease (mitral & aortic insufficiency — Years
DUE TO
(c) Bronchopneumonia — One day

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
Chronic Brain Syndrome associated with senile brain disease without qualifying phrase in a congenital microcephalic mental defective.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 9/24, 1959 to 10/10, 1960, that ☒ (we) last saw the deceased alive on 10/10 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Rita S. Glahn M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 10/11/60
22c. PHYSICIAN'S NAME (Type): Rita S. Glahn, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-13-60
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City, town, or county) (State): 3310 Taylor Avenue

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street
25a. REC'D BY REGISTRAR DATE: OCT 13 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be accepted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11251

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11261

1. PLACE OF DEATH
a. COUNTY: Carroll County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6 COURT ST EXT

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 6 COURT ST. EXT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olean — Middle: VIVIAN — Last: Woodyard

4. DATE OF DEATH: Month: OCT — Day: 22 — Year: 1960

5. SEX: F

6. COLOR OR RACE: COL

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 29 - 1918

9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY: HOUSE WORK

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HOWARD JONES

14. MOTHER'S MAIDEN NAME: ELIZABETH ADAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-20-4786

17. INFORMANT: HOWARD JONES — Address: NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

98 IX

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Wm. V. Lovett M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): WM. V. LOVETT

Address (Street, city, town, or county):

DATE SIGNED: 10/23/60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT 25 - 1960

22c. NAME OF CEMETERY OR CREMATORY: MT JOY

22d. LOCATION (City, town, or country): UNIONTOWN (State): MD

23. FUNERAL DIRECTOR: D.D. Hartzler & Sons — ADDRESS: New Windsor, Md.

24a. REC'D BY REGISTRAR: DATE OCT 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus